MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

03500 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred: Barnes Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL, and give nearest town)
Street No.: Gilla Hill (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Clara Alexander
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: James F. Alexander
6.(c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): September 15, 1898
8. AGE: Years 36 Months 7 Days 5 If less than one day ...hrs. ...min.
9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Thomas R. McFarlane
FATHER 13. Birthplace: Lonaconing, Md.
MOTHER 14. Maiden name: Mary M. Getson
MOTHER 15. Birthplace: Kirkintown
18. Informant: James H. Alexander
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: D. J. Cuthbert
Address: Lonaconing, Md.
19. 4-23 (Date rec'd by registrar) 19 45 Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 19 45 at 10 05 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15 19 45 to April 20 19 45 and that I last saw h. alive on April 20 19 45
Immediate cause of death: Metastatic Carcinoma DURATION 1 yr
Due to: Carcinoma breast
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hildegarde Walter M.D. M. D. or other
Address: Frostburg Md Date signed 4/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03501

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Monroe

City or town: R.F.D. #1 Keyser

(If outside city or town limits, write RURAL and give nearest town)

Street No. Keyser & Elkhorn Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Jane Anderson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 6 1940

8. AGE:

Years	Months	Days	If less than one day
4	10	20	..... hrs. ..... min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Jacob A Anderson

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Juanita Bosley

15. Birthplace: Iowa

16. Informant: Jack Anderson

Address: R.F.D. #1 Keyser W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 28 45 (month) (day) (year)

Cemetery or crematory: Mt Zion Cem

Location: R.F.D. #1 Keyser W. Va.

18. Funeral director: Lonio Stip. Inc.

Address: Cumberland

19. Apr 27 19 45 (Date rec'd by registrar) Vinton A Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 19 45 at 10 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 19 45, to Apr. 26 19 45 and that I last saw h.. alive on Apr. 26 19 45

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Acute myelitis cyst of lung, acute	4 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Same as #21

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D R Irons M.D.

M. D. or other

Address: Medical Bldg Date signed: 4-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Louis Bringe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

03502

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occured:
R.D.#5 Potomac Park
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.#5 Potomac Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Henry Bagley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Bosley Bagley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1862

8. AGE: Years	Months	Days	If less than one day
83	1	4	hrs. min.

9. Birthplace: Bedford Co. Penna.
(Town, county, and state)
10. Usual occupation: Celeanse Worker (Silk)
11. Industry or business: Celeanse Corp. Of America

FATHER
12. Name: William Bagley
13. Birthplace: Penna.

MOTHER
14. Maiden name: Jane Haney
15. Birthplace: Penna.

16. Informant: Mrs. Elizabeth Rose
Address: Waverly Terrace Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1945 (mouth) (day) (year)
Cemetery or crematory: St. Thomas Cemetery
Location: Bedford, Penna.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. April 30 1945 (Date rec'd by registrar) Walter L. Mauk, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1945 at 7:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1942, to April 28 1945
and that I last saw h alive on April 2 not 1945

Immediate cause of death	DURATION
arteriosclerotic gangrene of both lower legs	6 months
Due to: arteriosclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L Bringe M.D. M. D. or other
Address: Lonaconing Md Date signed 4-29-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03503

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 555 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Alleg.

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rene M. Baron

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Morris Baron.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16 1884

8. AGE:	Years	Months	Days	If less than one day
	60	10	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Weiner

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Rachel Bloom

MOTHER — 15. Birthplace: Poland

16. Informant: Morris Baron

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 9 45 (month) (day) (year)

Cemetery or crematory: East Kirk Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Apr 9 1945 (Date rec'd by registrar) Walter R. Bruce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1945 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 1945 to April 7 1945 and that I last saw h.er alive on April 6 1945

Immediate cause of death	DURATION
Myocardial Failure	
with Decompensation	??
Due to Hypertension	
Cerebrovascular Renal disease	??
Due to	
Other conditions Uremia	3 wks.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Reginald Jacobson M.D. M. D. or other

Address: 15 S. Liberty St. Date signed 4/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-1)

03504

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines, Md.

(If outside city or town limits, write RURAL (and give nearest town))

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines, Md.

(If outside city or town limits, write RURAL, and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laurence Beal

3. (b) Social Security Number 220-10-4166

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Frances Beal

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 21-1869

8. AGE:

Years	Months	Days	If less than one day
75	10	6	hrs. ..... min.

9. Birthplace Cumberland Alley, Md.
(Town, county, and state)

10. Usual occupation Retired Flushing Boss

11. Industry or business Columbia Gas Co.

FATHER 12. Name Patrick Beal

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Langsdon

15. Birthplace Ireland

16. Informant Arthur Beal

Address 30 Mahanna St. Barton

17. Burial, cremation, or removal. Which?

Date thereof 4-30-1945 (month) (day) (year)

Cemetery or crematory Potts Cemetery

Location Eckhart, Md.

16. Funeral director Jacob Walter

Address Frostburg, Md.

19. 4-30 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1945 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Apr. 27 1945, and that I last saw him alive on Apr. 24 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 ?
Due to Arterio Sclerosis	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane Jr. M.D.
M. D. or other

Address Frostburg Md. Date signed 4-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03505

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Garrett
City or town: Jennings (If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Miss Hazel Leon Bittinger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 10. 1917

8. AGE: Years 27 | Months 8 | Days 7 | If less than one day: hrs. min.

9. Birthplace: Jennings, Garrett, Md. (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business
FATHER 12. Name: John Thomas Bittinger
13. Birthplace: Route 1 Frostburg Md
MOTHER 14. Maiden name: Bessie Ellen Bittinger
15. Birthplace: Jennings, Md.
16. Informant: John Thomas Bittinger
Address: Rt. 1. Frostburg. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-19-1945 (month) (day) (year)
Cemetery or crematory: Berry Hill Cemetery
Location: at Home Garrett Co.
18. Funeral director: Allen Altenburg
Address: Grantsville Md
19. 4-17 (Date rec'd by registrar) 1945 Miss Nancy N. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945 at 2 10/15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/6 1945, to 4/17 1945 and that I last saw h. SX alive on 4/17 1945

Immediate cause of death	DURATION
Coronary Embolism	8 hrs
Due to: Post operative Embolism	
Due to: L Ovarian cyst (Follicular)	
Other conditions: Recurrent appendicitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Follicular cyst L ovary
Date of op. 4/16/45
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

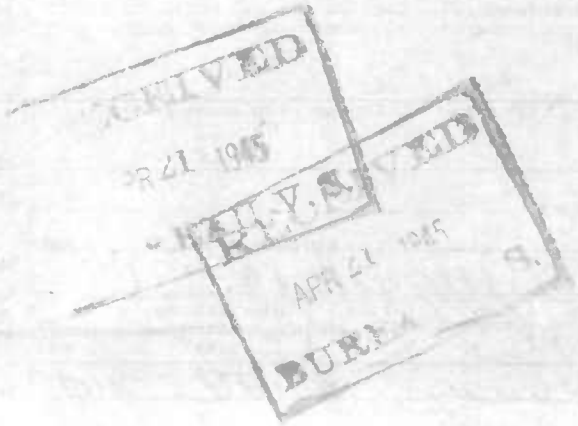
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Laurel Walters M.D.
M. D. or other
Address: Frostburg Date signed 4/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03506

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred: 321 Pennsylvania Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 321 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Holliday Boggs

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1926

8. AGE:

Years	Months	Days	If less than one day
18	4	9	..... hrs. ..... min.

9. Birthplace: Cumberland Allegany Co, Md (Town, county, and state)

10. Usual occupation: School Boy

11. Industry or business: Public School.

FATHER

12. Name: Herman Boggs

13. Birthplace: Oldtown Md.

MOTHER

14. Maiden name: Rosella Hull

15. Birthplace: Martins Ferry, Ohio.

16. Informant: Herman Boggs

Address: 321 Pennsylvania Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 16, 1945 (month) (day) (year)

Cemetery or crematory: Mt Olive Methodist Cemetery

Location: Near Oldtown, Md

18. Funeral director: John J Hafer

Address: Cumberland Md.

19. April 16, 1945 (Date rec'd by registrar) Walter R. Frantz M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1945 at 6:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45 to Apr. 13 19 45 and that I last saw him alive on Apr. 10, 19 45

Immediate cause of death	DURATION
Broncho-Pneumonia	6 days
Due to: Deformity of Extremities Atrophies	5 yrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay F. Turner M. D. or other

Address: Cumberland Date signed: 4/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03507

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Allegany
City or town Gilmore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Gilmore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Hannah J. Moore Bond
3.(b) Social Security Number —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John A. Bond
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): June 9, 1885

8. AGE: Years 59 Months 10 Days 10 If less than one day ... hrs. ... min.

9. Birthplace: Midland, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Francis Moore
13. Birthplace: Unknown
MOTHER 14. Maiden name: Jane Arthur Moore
15. Birthplace: Midland
16. Informant: John Bond
Address: Gilmore, Md.
17. Burial Date thereof April 22, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: W. Eichhorn
Address: Lonaconing, Md.
19 April 21 1945 W. E. Oon'tylor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/19 - 45 19 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/11/45 19 to 4/19/45 19
and that I last saw her alive on 4/19/45 19

Immediate cause of death	DURATION
Acute Cardiac dilatation	
Mitral stenosis	8 da
Due to Hypertension	Unk
Due to	

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE J. H. Matthews M. D. or other
Address 101 So. Centre St. Cumberland Date signed 4/21/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

03508

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr
Hospital, Institution, or street address where death occurred: 425 Penna Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Mc Coole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Vyzella Bonney

3.(b) Social Security Number: None

4. Sex: F.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: James E. Bonney
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov. 25, 1880

8. AGE: Years: 64 Months: 5 Days: 2 If less than one day: ..... hrs. ..... min.

6. Birthplace: Bloomington Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Henry Anthony Speker
FATHER 13. Birthplace: Lonaconing, Md.
MOTHER 14. Maiden name: Isabella Kazenbaker
MOTHER 15. Birthplace: Md.
16. Interment: James E. Bonney
Address: Lake, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-30-45 (month) (day) (year)
Cemetery or crematory: Philos
Location: Lake, Md.
16. Funeral director: N. S. Rogers Funeral Dir.
Address: Keyser W. Va.
19 April 27 19 45 Winter R. Frantz, M. D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 27, 1945 at 4:15 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 1, 1945 to Apr. 27, 1945
and that I last saw her alive on Apr. 25, 1945

	DURATION
Immediate cause of death: Bronchial Asthma	5 yrs.
Due to: Cardio-Vascular Renal Disease	2 yrs.
Due to: Arteriosclerosis	6 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clay E. Summers M. D.
Address: Cumberland Date signed 4/27/45 M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

03509

2411 N. Charles St., Baltimore (85-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

400. Decatur St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 400 Decatur St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ray Boyd

3.(b) Social Security Number: 210-09-1746

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Myers Boyd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 14 1873

8. AGE: Years	Months	Days	If less than one day
71	6	2	....hrs. ....min.

9. Birthplace: Connellsville, Fayette Co, Penna (Town, county, and state)

10. Usual occupation: Bookkeeper

11. Industry or business: James Motor Co

FATHER
12. Name: Joseph W. Stillwagon
13. Birthplace: Connellsville, Pa

MOTHER
14. Maiden name: Anna Gilmore
15. Birthplace: Connellsville, Pa.

16. Informant: Thomas Frazee

Address: 400. Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/45 (month) (day) (year)

Cemetery or crematory: Hill Grove Cemetery

Location: Connellsville, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 16, 1945 (Date rec'd by registrar) Wister R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1945 at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 1945 to April 16 1945 and that I last saw h.. alive on April 16 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 years
Due to: Hypertension	6 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md Date signed 4-16-45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-0)

CERTIFICATE OF DEATH

03510

Reg. Diat. No. 1

1. PLACE OF DEATH:
County: Allegany
City or town: Little Orleans (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs (Life)
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Little Orleans (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clara Willard Brinkman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed

6.(b) Name of husband or wife: Julius M. Brinkman (deceased) 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1858

8. AGE:

Years	Months	Days	If less than one day
87	2	17	____ hrs. ____ min.

9. Birthplace: Piney Grove, Allegany Co. Md. (Town, county, and state)
10. Usual occupation: Retired Housewife
11. Industry or business: Own home
FATHER 12. Name: James T. Hartley
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Ann Foster
15. Birthplace: Pennsylvania.
16. Informant: Mrs. Margaret Norris
Address: Little Orleans Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Apr. 15, 1945 (month) (day) (year)
Cemetery or crematory: Piney Plains cemetery
Location: Little Orleans R.F.D. 1
18. Funeral director: Ephraim Smith
Address: Artemas, Pa.
19. April 14 1945 (Date rec'd by registrar) T. T. Mumper McMann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1945 at 6 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944, to Apr. 12, 1945 and that I last saw her alive on Apr. 2, 1945

Immediate cause of death	DURATION
Acute myocarditis	10 days
Due to: Arteriosclerosis	1 yr.
Due to:	
Other conditions: Senile dementia (Include pregnancy within 3 months of death)	1 yr.

Major findings of operation: / Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M.D. (M. D. or other)
Address: Little Orleans Md. Date signed Apr. 13, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

03511

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

435 Race St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 435 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Daniel Webster Brinkman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Bertha Caspiro

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1870

8. AGE:	Years	Months	Days	If less than one day
	75	2	17	..... hrs. ..... min.

9. Birthplace Town Hill, Allegany, Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Building trades

FATHER 12. Name Frederick Brinkman

13. Birthplace Holland

MOTHER 14. Maiden name Mary Slider

15. Birthplace ?

16. Informant Mrs Edna E. Hardy

Address 435 Race St - Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1945 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md

18. Funeral director John J. Hofer

Address Cumberland, Md

19. April 21, 1945 (Date rec'd by registrar) Walter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to Apr. 18, 1945

and that I last saw h[illegible] alive on Apr. 13, 1945.

	DURATION
Immediate cause of death Carcinoma of Sigmoid	10 m
Due to Metastasis to Spine	8 m
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Simms M. D. or other

Address Cumberland Date signed 4/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Cy Bowers
Glacier Bunk Park

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03512

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, Institution, or street address where death occurred: 220 Thomas

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Thomas St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Burrell P. Brown

3.(b) Social Security Number: 220-10-7598

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Libby M. Brown.

B.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): Dec. 23 1879.

8. AGE: Years	Months	Days	If less than one day
65	3	9.	hrs. min.

9. Birthplace: Rawlings Md.

(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: General.

FATHER — 12. Name: Albert Brown

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Agnes Cook.

15. Birthplace: Va

16. Informant: Mrs Anna M. Hurst

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 4 '45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Cumberland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland.

19. April 4 (Date rec'd by registrar) 19 45 Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 1. 19 45 at 1 55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 26. 19 45 to Apr. 1. 19 45

and that I last saw h alive on Apr. 1. 19 45

Immediate cause of death	DURATION
Uraemia	4 wks
Due to Arteriosclerosis	yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clark L. Jones M.D. or other

Address: Cumberland Date signed Apr. 2, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5-F-C

03513

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 Years

Hospital, institution, or street address where death occurred:
119. Hanover St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 119. Hanover St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Patrick Richard Burns

3.(b) Social Security Number: 705-12-2353

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Burns

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 8, 1885

8. AGE: Years	Months	Days	If less than one day
60	1	3	...hrs. ...min.

9. Birthplace: Midland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: Garrette Burns
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Esther Cavanugh
15. Birthplace: Ireland

16. Informant: Mrs. Partick R. Burns

Address: 119. Hanover St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14 1945 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 11 19 45 (Date rec'd by registrar) Winter R. Hanby M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 19 45 at 5-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 19 43 to April 11 19 45 and that I last saw h... alive on April 2 19 45

Immediate cause of death	DURATION
cancer of the prostate	17 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: L Burns MD
M. D. or other

Address: Lonaconing Md Date signed 4-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

03314

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGHENY CO.

City or town CUMBERLAND MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 DAYS

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County SOMERSET

City or town MEYERSDALE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 308 FRONT STREET

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME REV. SANFORD CARPENTER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife MARY EDNA FOUGH

6.(c) If alive, give age 61 yrs.,

7. Birth date of deceased (mo., day, yr.) DEC. 4, 1872

8. AGE: Years	Months	Days	If less than one day
72 YRS.	3	28	..... hrs. ..... min.

9. Birthplace PENNA. (Town, county, and state)

10. Usual occupation LUTHERAN MINISTER

11. Industry or business [redacted]

FATHER 12. Name Unknown Carpenter

13. Birthplace PENNA.

MOTHER 14. Maiden name SARAH FREED

15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/45 (month) (day) (year)

Cemetery or crematory Boonsboro, Md.

Location Washington Co., Md.

18. Funeral director H. P. Workman

Address Meyersdale, Pa.

19 April 5 19 45 Winter R. Bantz M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 2, 1945 at 3:03 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 2 1945 to April 2 1945

and that I last saw h[illegible] alive on April 1 1945

Immediate cause of death ..... DURATION

(a) Acute myocardial failure 1

Due to, or as a consequence of (b) Following

Due to, or as a consequence of (c) Prolonged diarrhea 3 wks

Due to, or as a consequence of (d) Performed for Cholecystitis

Other conditions Chr. Myocarditis 7

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. 3-12-45

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other

Address Cumberland Md. Date signed 4-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03515

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart Mines Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Evelyn Rosa Close

3.(b) Social Security Number: 212-01-9811

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 20th. 1901

8. AGE: Years: 43 Months: 6 Days: 28 If less than one day: hrs. min.

9. Birthplace: Eckhart Allegany, Md. (Town, county, and state)

10. Usual occupation: Operated Machine

11. Industry or business: Papaya Factory

FATHER

12. Name: James Close

13. Birthplace: Eckhart Md.

MOTHER

14. Maiden name: Elizabeth Beadle

15. Birthplace: Bottle Shaft, Md.

16. Informant: Wm. Close

Address: 415 Byll St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 21-1945 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

18. Funeral director: Jacob Kaler

Address: Frostburg, Md.

19. 4-19 1945 (Date rec'd by registrar) Mrs. Nancy N. Roe (Registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: April 18 1945 at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to April 18 1945

and that I last saw her alive on April 18 1945.

Immediate cause of death	DURATION
acute dilitation of heart	5 min.
Due to: General Paresis	3 yrs.
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please nuderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D., or other

Address: Frostburg, Md. Date signed: 4/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

03516

CERTIFICATE OF DEATH

Reg. Diat. No. 7

1. PLACE OF DEATH:

County Allegany

City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Amelia Catherine Conn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Elmer Conn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	22	..... hrs. ..... min.

9. Birthplace Barton Alleg Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name John V. Linta

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Margaret Heidner

MOTHER 15. Birthplace Germany

16. Informant Mrs. Wm. Bernard

Address Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 25 1945 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Mascow Md.

18. Funeral director Mrs. Jay Boyd Berry

Address Westernport, Md.

19. April 24 1945 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1945 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to April 22 1945

and that I last saw h.x alive on April 22 1945

Immediate cause of death	DURATION
Carcinoma of Uterus (Cervix)	1 yr.
Due to	
Due to	
Other conditions Bronchus Pneumonia (Terminal)	2 days

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman Reeves M.D.

M. D. or other

Address Westernport, Md Date signed 4-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03517

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town) Md

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital, Cumberland, Md.

How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Wiley Ford (If outside city or town limits, write RURAL and give nearest town) W. Va.

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Boy Boy Crites

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-1945

8. AGE: Years | Months | Days | If less than one day: hrs. 20 min.

9. Birthplace Cumberland Allegany Md (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Roy J. Crites

FATHER 13. Birthplace Moorefield W Va

MOTHER 14. Maiden name Cornelia Lynn Rogers

MOTHER 15. Birthplace Edinburg Va.

18. Informant Roy J. Crites

Address Wiley Ford W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/11/45 (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland Md

18. Funeral director William H. Kight

Address Cumberland Md

19. April 11 1945 Hunter R. Dantz M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/10 1945, at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 10 1945 to April 10 1945 and that I last saw h... alive on April 10 1945

Immediate cause of death	DURATION
Asphyxia Neonatorum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson Jr. M.D. M. D. or other

Address Cumberland, Md Date signed 4-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 58-d

CERTIFICATE OF DEATH

03518

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Artemas - Route 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME
Mrs. Clara Curren

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Daniel Curren
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): September 26, 1890

8. AGE: Years	Months	Days	If less than one day
54	6	23	....hrs. ....min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Smith
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Clingerman
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 1945 (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Inglesmith, Pa.
18. Funeral director: John L. Hafer
Address: Cumberland, Md.

19. April 21 1945 (Date rec'd by registrar) Walter L. Rantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1945 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 16, 1945, to Apr. 19, 1945
and that I last saw her alive on Apr. 18, 1945

Immediate cause of death	DURATION
Pneumonia; Cardiac - Fatty Dilatation	
Due to: Pneumonia	weeks.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clara L. Curren M.D. or other
Address: Cumberland Date signed 4/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03519

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo

Hospital, institution, or street address where death occurred:
339 Frederick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 339 Frederick St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Diane Marta Darr

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Negro	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 14, 1945

8. AGE: Years | Months: 1 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Allegany, Md
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: John Norwood Darr
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Marie Hicks
15. Birthplace: Norfolk, Va.

16. Informant: John N. Darr
Address: 339 Frederick St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 13 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland, Md.

18. Funeral director: John J. Hafey

Address: Cumberland, Md.

19. April 13, 1945 (Date rec'd by registrar) Walter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1945 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 13 1945 to April 11 1945 and that I last saw h... alive on April 11 1945

Immediate cause of death	DURATION
Bronchopneumonia	7 days
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

28. SIGNATURE: Walter R. Krantz M.D. M. D. or other

Address: 330 Baltimore St. Date signed 4/13/45

-M.C.B. Covers-

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03520

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY COUNTY
City or town: CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~1 day~~ 34 years
Hospital, Institution, or street address where death occurred: Memorial Hospital, Cumberland, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or near: CUMBERLAND, MD, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #2, WILLIAMS ROAD (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SOLOMON P. DAVIS

3.(b) Social Security Number: 220-10-0620

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: IVA MAE PHARES DAVIS
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): ~~DEC~~ JUNE 9. 1887

8. AGE:

Years	Months	Days	If less than one day
57	9	19	....hrs. ....min.

9. Birthplace: Grant County, W.Va. (Town, county, and state)
10. Usual occupation: CONSOLIDATED ORCHARD CO.
11. Industry or business:
FATHER 12. Name: [redacted]S DAVIS, Cornelius
13. Birthplace: W.VA.
MOTHER 14. Maiden name: Susan R. Van Meter
15. Birthplace: W.VA.
16. Informant: Ida Mae Phares Davis
Address: R.F.D. #2 Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 2 1945 (month) (day) (year)
Cemetery or crematory: Augusta, W.Va.
Location: Augusta, W.Va.
18. Funeral director: McKee Funeral Home
Address: Augusta, W.Va.
19. April 29 19 45 (Date rec'd by registrar) Walter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 28, 1945 19.... at 7:55PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 45 to April 28 45 and that I last saw h.. alive on April 28 19 45

Immediate cause of death: Gastric hemorrhage — DURATION: 2 days

Due to: Undetermined origin.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Royce Hodgson II M. D. or other
Address: Cumberland, Md. Date signed: 4/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74

03521

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs
Hospital, institution, or street address where death occurred: 43 N Mechanic St (Rear)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 43 N Mechanic St (Rear)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Melvin Deremer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 24 1906

8. AGE:

Years	Months	Days	If less than one day
38	8	3	____ hrs. ____ min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Wilbur A Deremer
13. Birthplace: Md.

MOTHER
14. Maiden name: Laura C Crabtree
15. Birthplace: Md.

16. Informant: Wm A Deremer
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 30 45 (month) (day) (year)
Cemetery or crematory: Union Mem. Gdns
Location: Oldtown Rd.

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. April 30 1945 (Date rec'd by registrar) Walter R Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27th., 1945, at about 1P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions: Hunchback (chronic alcoholism)	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Pierce H. Bosley M.D.
M. D. or other
Address: Cumberland, Maryland Date signed 4-27-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

03522

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 519 Averett Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Leo T Downey

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Theresa Waters
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec 24, 1884

8. AGE:

Years	Months	Days	If less than one day
60	3	19	...hrs. ...min.

9. Birthplace: Alexander Va.
(Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: State Road Com.

FATHER
12. Name: Michael Downey
13. Birthplace: Va.

MOTHER
14. Maiden name: Julia Dunn
15. Birthplace: Va.

16. Informant: Theresa Downey
Address: Cumberland.

17. Burial, cremation, or removal (Which?): Burial Date thereof (month) Apr (day) 16 (year) 45
Cemetery or crematory: St Peter & Paul's Cem
Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: Cumberland

19. (Date rec'd by registrar) April 16 1945 Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-13-1945 at 4:28 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11.24.1936 to 4.13.1945 and that I last saw him alive on 4.13.1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	One hr.
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 4-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important.—Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

03523

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 Broadway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Nelson Durst

3.(b) Social Security Number 215-10-4497

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Heliodore C. Durst
6.(c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.): October 19, 1897

8. AGE: Years 47 Months 6 Days 0 If less than one day ... hrs. ... min.

9. Birthplace: Frostburg Allegany City. Md.
(Town, county, and state)
10. Usual occupation: truck driver
11. Industry or business: Furniture + undertaking
FATHER 12. Name: Jonas J. Durst
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sallie W. Layman
15. Birthplace: Maryland
16. Informant: Anna Durst
Address: Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 22 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md
19. 4-21 1945 (Date rec'd by registrar) Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1945 to April 19 1945 and that I last saw him alive on April 19 1945.

Immediate cause of death: Severe Cerebral Concussion with tearing of brain

Due to: tissue near base of brain. — DURATION: 4 days.

Due to: No evidence of fracture of skull

Other conditions: shown on X-Ray.

(Include pregnancy within 3 months of death)

Major findings of operations: X
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~: accident Date of: 4-16-45
Where did injury occur? Finzel, Garrett Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) State highway
Means of injury: auto hit truck driven by Durst—throwing him on to road. Injured at work? yes

23. SIGNATURE: H. C. Diehl M.D. (M. D. or other)
Address: Frostburg, Md. Date signed: 4/21/45

I

Dr. Topper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03524

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Buffalo Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mr. Frank Emerick

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Gloria Shroyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 31, 1873

8. AGE: Years	Months	Days	If less than one day
72	2	25	hrs. min.

9. Birthplace: Bedford Co, Penna (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Lafayette Emerick
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Mary Clites
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 1945 (month) (day) (year)
Cemetery or crematory: Lyborger
Location: Hyndman R.D.1.

18. Funeral director: H. H. Leigler
Address: Hyndman, Pa.

19. April 29 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1945, at 9 ~~P~~ OP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 2 1945, to Apr 26 1945
and that I last saw h... alive on Apr 26 1945

Immediate cause of death	DURATION
Basilar Meningitis	2 Days
Due to: Infection 3rd degree Burns of Hands and Head	2½ wks.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Topper MD
M. D. or other
Address: Hyndman Pa. Date signed 4/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03525

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred: 109 Baltimore St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 7 Lavale (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Colvin Evans

3. (b) Social Security Number: 705-09-3751

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Forbeck
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): October 26, 1899

8. AGE: Years	Months	Days	If less than one day
45	6	0	hrs. min.

9. Birthplace: Hyndmans Bedford Co. Penna (Town, county, and state)
10. Usual occupation: B+O Tratchman
11. Industry or business: R. R. Co.
FATHER 12. Name: John Evans
13. Birthplace: Hyndman, Pa
MOTHER 14. Maiden name: Alice Evans
15. Birthplace: Hyndman Pa
16. Informant: Bertha Forbeck Evans
Address: Cumberland, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 30 1945 (month) (day) (year)
Cemetery or crematory: Hyndman
Location: Hyndman, Pa
18. Funeral director: Harvey W. Zeigler
Address: Hyndman, Pa.
19. April 29 1945 (Date rec'd by registrar) Winter P. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26th, 1945, at 6.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Prince H. Bolton, M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 4-26-45

County Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

03526

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr
Hospital, Institution, or street address where death occurred:
Baltimore Ohio Roland House Jail
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penn. County Fayette
City or town Connellsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Michael J. Fabian

3.(b) Social Security Number 705-09-5656

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1890 ?

8. AGE: Years 55 | Months ? | Days ? | If less than one day ..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Conductor

11. Industry or business B. and O. R. R. Co.

FATHER 12. Name Michael J. Fabian
13. Birthplace Europe

MOTHER 14. Maiden name Susan Sukar
15. Birthplace Europe

16. Informant Munk Funeral Home
Address Connellsville, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27, 1945 (month) (day) (year)
Cemetery or crematory Green Ridge Memorial Park
Location Connellsville, Penna.

18. Funeral director Munk Funeral Home
Address Connellsville, Penna.

19. April 25 1945 (Date rec'd by registrar) Winter L. Hauntz, M.D. Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH April 24th., 1945, at 1.45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull-frontal	
Right arm severed at shoulder	5 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---
Date of op.
Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 4-24-45
Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) R.R. Yard
Means of injury ran over by engine Injured at work? yes

23. SIGNATURE Pierce H. Brown M.D.
M. D. or other
Address Cumberland, Maryland. Date signed 4-25-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03527

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or towu limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Flintstone
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Earl Murry Fletcher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 22, 1931

8. AGE: Years	Months	Days	If less than one day
13	6	27	..... hrs. ..... min.

9. Birthplace: Maryland - Flintstone, Alleg. Co.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: James K. Fletcher
13. Birthplace: Maryland - Flintstone

MOTHER
14. Maiden name: Thelma Knippenberg
15. Birthplace: Maryland - Cumberland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Hope Cemetery
Location: Near Artemas, Pa.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. April 21 1945 Winter R. Beantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1945 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1945 to about 1945
and that I last saw h.. alive on April 18 1945

Immediate cause of death	DURATION
Respiratory Failure	1 day
Circulatory Failure	1 day
Due to Laryngeal Croup	4 days
Due to Acute Infection	
Other conditions Acute Nephritis	4 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Eliason M.D.
M. D. or other
Address: Cumberland, Md. Date signed 4/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03528

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs

Hospital, Institution, or street address where death occurred:

903 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 903 Virginia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Fannie May Foreman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Louis F. Foreman

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 4, 1865

8. AGE: Years	Months	Days	If less than one day
79	11	7	...hrs. ...min.

9. Birthplace Harpers Ferry W. Va.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

FATHER 12. Name John Smith

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant John Foreman

Address 903 Va. Ave. Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 13, 1945 (month) (day) (year)

Cemetery or crematory Mt. Herman

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. April 13, 1945 (Date rec'd by registrar) Whitley P. Hauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1945 to April 11 1945 and that I last saw h... alive on April 11 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3 hrs.
Due to Arteriosclerosis	8 yrs.
Due to Arteriosclerosis	6 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. E. Bowers M. D. or other

Address 332 Va Ave Date signed 4/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

03529

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 416 Cumberland St.
(If rural, give LOCATION)

2.(n) If veteran, name war

3.(a) FULL NAME Mary Theresa Fradiska

3.(b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Joseph M. Fradiska

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22 1892

8. AGE: Years 52 | Months 9 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: John Quan
13. Birthplace: Md

MOTHER
14. Maiden name: Anna Brooks
15. Birthplace: Md

16. Informant: Joseph M Fradiska
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 26 1945 (month) (day) (year)

Cemetery or crematory: St P. & P. Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. April 25 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1945 at 9.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1945 to April 23 1945 and that I last saw h.r alive on April 23 1945

Immediate cause of death	DURATION
Arterial Embolism Rt. Com. Femoral	12 hrs.
Due to: Auricular Fibrillation	?
Coronary Artery Disease	?
Due to: Myocardial Disease	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Embolus Rt. Femoral Artery

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Stanley Jankowski M.D. or other

Address 15 S. Liberty St. Date signed 4/24/45

03530

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-3)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40. Years
Hospital, Institution, or street address where death occurred:
231. Independence St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 231. Independence St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Arbella Gorsuch

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George Gorsuch
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 14 1873

8. AGE: Years	Months	Days	If less than one day
72	2	21	..... hrs. ..... min.

9. Birthplace: Bedford Co. Penna (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own House

FATHER
12. Name: James Smith
13. Birthplace: Bedford Co, Penna

MOTHER
14. Maiden name: Sarah Jay
15. Birthplace: Bedford Co, Penna

16. Informant: Troy W. Gorsuch
Address: 517. Fectig Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/8/45 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. April 8, 1945 (Date rec'd by registrar) Winters R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1945 19 45 at 3-P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/23/44 19 ..... to 4/6-/45 19 .....
and that I last saw h. alive on 4/5-/45 19 .....

	DURATION
Immediate cause of death: Mitral Heart disease	1 yr
Due to: Artem Sclerosis	Yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. H. Matthews M. D. or other
Address: 501 S. Center St Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

T 03531

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:
County: Allegany
City or town: Pekin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? c
Hospital, Institution, or street address where death occurred: c
How long in hospital or institution? c

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Moscow
(If outside city or town limits, write RURAL and give nearest town)
Street No. c
(If rural, give LOCATION)
2.(a) If veteran, name war: c

3.(a) FULL NAME: Thomas Gray

3.(b) Social Security Number: c

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife: c
B.(c) If alive, give age: c years

7. Birth date of deceased (mo., day, yr.): July 20, 1874

8. AGE: Years 70 | Months 9 | Days 2 | If less than one day: hrs. min.

9. Birthplace: Moscow, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Own Farm

FATHER
12. Name: Thomas Gray
13. Birthplace: Wales

MOTHER
14. Maiden name: Mary Ann Farmdland
15. Birthplace: Wales

16. Informant: Graham Gray
Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24th 1945 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Moscow, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. April 22 1945 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

A. M.

20. DATE OF DEATH: April 22nd., 1945, at 12:05

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Crushed chest (fractures and extensive lacerations)	
Due to	
Due to	Killed instantly.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: under investigation Date of injury:
Where did injury occur? Pekin, (City or town) Allegany, (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: struck by auto Injured at work? no

23. SIGNATURE: Bruce H. Brown, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 4-22-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03536

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred: 915 Rolling Mill alley.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 W. 3rd St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wesley Hamilton

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Myrtle Weller

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Dec 2, 1873

8. AGE: Years	Months	Days	If less than one day
71	4	11	hrs. min.

9. Birthplace: Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General Farming

FATHER 12. Name: Geo. R. Hamilton

FATHER 13. Birthplace: Allegany Co., Md.

MOTHER 14. Maiden name: Mary S. Twigg

MOTHER 15. Birthplace: Md.

16. Informant: Mrs. Ruth G. Stein

Address: 8 W. 3rd St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 15, 1945 (month) (day) (year)

Cemetery or crematory: Mt Herman Cemetery

Location: Near Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. April 15, 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1945, at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Pierce H. Bowen, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 4-14-45

Deputy Medical Examiner - Allegany Co.

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (145)

CERTIFICATE OF DEATH

03532

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 Years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE #3, VALLEY ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HARTMAN, MARILYN MRS.

3.(b) Social Security Number 218-16-4894

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife KENNETH E. HARTMAN
6.(c) If alive, give age 21 years
7. Birth date of deceased (mo., day, yr.) JUNE 14 1923

8. AGE: Years	Months	Days	If less than one day
21	10	3	..... hrs. ..... min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual occupation Clerk WIFE
11. Industry or business Murphy's Dept. Store

FATHER
12. Name WILLIAM S. BOYD
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden name HAZEL MAE CARSON
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/20/45 (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown, Md.
18. Funeral director William H. Kight
Address Cumberland, Md.

19 April 19, 19 45 Winter R. Frantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 17 19 45, at 11:25A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 5 19 45 to April 17 19 45.
and that I last saw her alive on April 17 19 45.

Immediate cause of death (1) Cardio-renal disease complicating
Due to (2) Hydatid form mole
Due to (3 months)
Other conditions

DURATION

(Include pregnancy within 3 months of death)
Major findings of operations Hydatidiform mole
Date of op. 4/8/45
Autopsy results Hydatid. mole — acute nephritis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Royce Hodges, M.D.
M. D. or other
Address Cumberland, Md. Date signed 4/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MA)

03533

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city nr town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs

Hospital, institution, or street address where death occurred: 320 Dorn Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 320 Dorn Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Martha Jane Helmick. | **3.(b) Social Security Number** None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife Chas H. Helmick.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 29, 1858

8. AGE: Years	Months	Days	If less than one day
86	10	16	..... hrs. ..... min.

9. Birthplace Winfield, Marion Co., W. Va. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name Joseph Marley

13. Birthplace Winfield, W. Va.

MOTHER 14. Maiden name Marky Reed

15. Birthplace Winfield W. Va.

16. Informant John H. Helmick.

Address 320 Dorn Ave - Cumb. Md.

17. Burial (Burial, cremation, nr removal. Which?) Date thereof April 18, 1945 (month) (day) (year)

Cemetery or crematory Maple Grove Cemetery

Location Fairmont W. Va.

18. Funeral director John J. Hafer.

Address Cumberland, Md.

19. April 17 1945 Walter R. Frantz, M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1945 at 2:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Bolton, M.D. M. D. nr other

Address Cumberland, Maryland Date signed 2-16-45

Deputy Medical Examiner - Allegany Co.

Cor507

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

03534

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland Md

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 251 N. Mechanic (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry H. Hinkebein Hinkebein Harry

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 26 1883

8. AGE: Years	Months	Days	If less than one day
62	0	14	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

FATHER 12. Name Henry Hinkebein

13. Birthplace Md.

MOTHER 14. Maiden name Leopoldina Fillinger

15. Birthplace Germany

16. Informant Mrs Lola Grant

Address Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 10 1945 (month) (day) (year)

Cemetery or crematory St Lukas Cem

Location Cumberland Md

18. Funeral director Louis Steen Sons

Address Cumberland Md

19. April 10 1945 (Date rec'd by registrar) Winter L. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 1942, to April 8 1945

and that I last saw h... alive on ..... 19...

	DURATION
Immediate cause of death acute coronary occlusion	2 days
Due to chronic myocard. deg.	3 years
Due to arteriosclerosis	
Other conditions diabetes	many years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L Brinn MD (M. D. or other)

Address Lonaconing Md Date signed 4-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G 9 4 MAY 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03535 K-5

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Potomac Park.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Potomac Park.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Hinebaugh

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: LeRoy Hinebaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 7 1897

8. AGE: Years	Months	Days	If less than one day
48 58	1	10	..... hrs. ..... min.

9. Birthplace: Pennsa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Bowers
13. Birthplace: Pa.

MOTHER
14. Maiden name: Janette Walker
15. Birthplace: Pa.

16. Informant: LeRoy Hinebaugh
Address: Potomac Park.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 15 '45 (month) (day) (year)

Cemetery or crematory: Good Cem.

Location: Salisbury Pa.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. April 14 1945 (Date rec'd by registrar) M E Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945, at 9 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 1944, to April 12 1945

and that I last saw h[illegible] alive on April 2 1945

	DURATION
Immediate cause of death: acute coronary occlusion	12 hours
Due to: arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L M Irvin M D
M. D. or other

Address: Long Mot Date signed 4-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

03537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, Institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 8 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 755 CLEVELAND AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARY E. HIPSLEY

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife WILLIAM B. HIPSLEY

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB. 26 1867

8. AGE: Years	Months	Days	If less than one day
78	1	17	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own House

FATHER 12. Name NATHANIEL E. CHANEY

13. Birthplace MARYLAND

MOTHER 14. Maiden name MARTHA BEALE

15. Birthplace MARYLAND

16. Informant Thomas C Speake

Address 755. Cleveland Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/45 (month) (day) (year)

Cemetery or crematory Marvin Chapel Cemetery

Location (Near) Frederick, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. April 15, 1945 (Date rec'd by registrar) Walter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 13, 1945 at 6:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-1945 to 4-13-1945 and that I last saw h.. alive on 4-13-1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension,	?
Due to Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M.D. or other

Address Cumberland Date signed 4.14.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

03538

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Co. Infirmary

How long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Route 40 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Jackson

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Unknown

8.(b) Name of husband or wife Alice Sowers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11 1877

8. AGE: Years	Months	Days	If less than one day
67	11	6	..... hrs. ..... min.

9. Birthplace Maryland (town, county, and state)

10. Usual occupation Engineer-Retired

11. Industry or business

FATHER 12. Name William Jackson

13. Birthplace Virginia

MOTHER 14. Maiden name Mary Carter

15. Birthplace Maryland

16. Informant Celana Demmare

Address Chicago Illinois

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1945 (month) (day) (year)

Cemetery or crematory St Mary Burial Park

Location Old Hightway

18. Funeral director Gaines Stein Inn

Address Cumberland Md

19. April 8 1945 Winter R. Kantz, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1945, at 1450 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1944, to 4-5-45 1945

and that I last saw him alive on 4-4-45 1945

Immediate cause of death	DURATION
Myocardial Degeneration	
Due to Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 4-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03539

CERTIFICATE OF DEATH

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Allegany.

City or town: Westernport,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 121 Johnson
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Frank Cromer Jamesson.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Jamesson.

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1864.

8. AGE: Years	Months	Days	If less than one day
81	2	4	hrs. min.

9. Birthplace: Westernport, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Retired.

11. Industry or business: Merchant

FATHER
12. Name: William Jamesson.
13. Birthplace: Oldtown, Maryland.

MOTHER
14. Maiden name: Maria Mountz
15. Birthplace: Maryland.

16. Informant: Mrs. Mary Jamesson.
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1945 (month) (day) (year)

Cemetery or crematory: Philos Cemetery.

Location: Westernport, Md.

18. Funeral director: C. H. Friedlock

Address: Piedmont, West Va.

19. Apr. 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1945 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1943 to Apr. 10 1945 and that I last saw h.. alive on April 10 1945

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs
Due to: arteriosclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P E Berry M. D. or other

Address: Piedmont W Va Date signed 4/11/45

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-M)

CERTIFICATE OF DEATH

03540

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME BABY GIRL KITZMILLER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	INFANT

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 18, 1945

8. AGE: Years	Months	Days	If less than one day
		3	..... hrs. ..... min.

8. Birthplace CUMBERLAND, MARYLAND (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name GABRIEL S. KITZMILLER
13. Birthplace W.VA.

MOTHER
14. Maiden name PEARL METHNER
15. Birthplace W.VA.

16. Informant Memorial Hospital
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal). Which?
Date thereof April 22, 45 (month) (day) (year)
Cemetery or crematory Odd Fellows
Location Westernport Md.
18. Funeral director E. L. Acworth & Bro.
Address Westernport Md.

19. April 22, 19 45 (Date rec'd by registrar) Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 21, 1945 19 at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 19, 1945 to Apr. 21, 1945 and that I last saw ... alive on Apr. 21, 1945

	DURATION
Immediate cause of death Cardiac Collapse	Instant
Due to Chest was abnormal with part unexpanded	
Due to and deformed	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clark L. Jones M. D. or other
Address Cumberland Date signed 4/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

03541

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital Cumberland, Md

How long in hospital or institution? 158 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8 Smith Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kline Louis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Kline

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 27 1885

8. AGE: Years	Months	Days	If less than one day
59	6	12	..... hrs. ..... min.

9. Birthplace: Rumania (Town, county, and state)

10. Usual occupation: Proprietor

11. Industry or business: Clothing Store

FATHER

12. Name: Simon Kline

13. Birthplace: Rumania

MOTHER

14. Maiden name: Esther Robinson

15. Birthplace: Rumania

16. Informant: Mrs. Carrie M. Kline

Address: 8 Smith St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10, 1945 (month) (day) (year)

Cemetery or crematory: Eastview Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. 4-9-45 19..... (Date rec'd by registrar) Victor A. Crouse Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/9 19 45, at 10:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-31-42 19..... to 4-9-45 19.....

and that I last saw h... im alive on 4-8-45 19.....

Immediate cause of death	DURATION
Diabetes mellitus	27 mo.
Due to: Diabetic gangrene	8 wks.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: O. G. Zimmerman M.D. M. D. or other

Address: Cumberland, Md. Date signed 4-9-45

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03542

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred: Died enroute to Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Wood Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Aloysious Langan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary R. Langan

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): March 16, 1892

8. AGE: Years	Months	Days	If less than one day
53		17	...hrs. ...min.

9. Birthplace: Baltimore Maryland
(Town, county and state)

10. Usual occupation: Businessman

11. Industry or business: Candy Business

FATHER — 12. Name: John Langan

FATHER — 13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Ellen Finn

MOTHER — 15. Birthplace: Baltimore, Maryland

16. Informant: Edward J. Ryan

Address: 75 Frost Avenue, Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/6/45 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Maryland

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. 4-5 (Date rec'd by registrar) 19 45 Wm. Nancy H.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden to Death 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm Lane Jr MD M.D. or other

Address: Frostburg Md Date signed: 4-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

03543

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred: 703 Greene St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 703 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Ruth Gibbons Lynn

3.(b) Social Security Number 215-14-6081

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife John B. Lynn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 15 1878

8. AGE:	Years	Months	Days	If less than one day
	66	4	27	..... hrs. ..... min.

9. Birthplace Fairmont W. Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER — 12. Name Geo. Allen Gibbons

13. Birthplace W. Va.

MOTHER — 14. Maiden name Lura Ann Bloom

15. Birthplace W. Va.

16. Informant Page Lynn

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 14 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland, Md

18. Funeral director Louis Stein Son

Address Cumberland

19. April 14 1945 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1945 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-10-44 to 4-12-45

and that I last saw h.. alive on 4-12-45

Immediate cause of death Coronary Thrombosis

Due to Coronary Arteriosclerosis

Due to .....

Other conditions .....

DURATION: 8 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 4-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03544

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50. Years

Hospital, institution, or street address where death occurred:
606. Elwood St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 606. Elwood St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Amanda Martin

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Leven Martin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 4 1866

8. AGE: Years	Months	Days	If less than one day
78	4	6	..... hrs. ..... min.

9. Birthplace: Purcell, Bedford Co, Penna
(Town, county, and state)

10. Usual occupation: House Duty

11. Industry or business: Own House

FATHER
12. Name: Christopher Crawford
13. Birthplace: Bedford Co, Penna

MOTHER
14. Maiden name: Rachel Pennell
15. Birthplace: Bedford Co, Penna

16. Informant: Mrs. R. L. Taylor

Address: 606. Elwood St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13, 1945 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Fairview, Pa.

16. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 11, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1945, at 7-10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 5. 1945, to Apr. 10. 1945

and that I last saw h[illegible] alive on Apr. 9. 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 yrs.
Due to: Cerebral Haemorrhage	5 days
Due to: Uraemia	5 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clayton L. Turner M. D. or other

Address: Cumberland Date signed Apr. 10, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

03545

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Bro B.R.C. Shops

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Alleg

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 1/2 Baltimore St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Adam Martin

3.(b) Social Security Number 705-09-9864

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 30, 1880

8. AGE: Years	Months	Days	If less than one day
64	11	21	..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Machinist Helper

11. Industry or business: R.R. Co

FATHER 12. Name: Martin Martin

13. Birthplace: Ger.

MOTHER 14. Maiden name: Margaret Stallings

15. Birthplace: Ger

16. Informant: John Martin

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof apr 25 1945 (month) (day) (year)

Cemetery or crematory: Ger. Bap. Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. April 25 19 45 (Date rec'd by registrar) Winter L. Beauty M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: April 22nd., 19 45, at 11:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Bruce H. Brown M.D.

M. D. or other

Address: Cumberland, Maryland Date signed 4-22-45

Deputy Medical Examiner for Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (III-a)

CERTIFICATE OF DEATH

03546

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 463 GOETHE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MATLICK, EUNICE Victoria

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1891

8. AGE: Years 53 | Months 11 | Days 19 | If less than one day hrs. min.

9. Birthplace Listonburg, Somerset County, Penna (Town, county, and state)

10. Usual occupation REGISTERED NURSE

11. Industry or business

FATHER
12. Name MATLICK, CHAS.
13. Birthplace W.VA., Brandonville

MOTHER
14. Maiden name WILHELM, ~~NELLA~~ Almyra
15. Birthplace PA., Listonburg

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 25, 1945 (month) (day) (year)
Cemetery or crematory Rose Hill Cem
Location Cumberland, Md.

18. Funeral director John J. Hafer
Address Cumberland, Md.

19. April 25, 19 45 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

DR. ENFIELD

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22, 1945 at 11:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 All 1945 to 4-22- 1945 and that I last saw h[illegible] alive on Apr. 22 - 1945

Immediate cause of death Pulmonary Embolism Massive

DURATION 15'

Due to X

Due to Leukocytosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Supp. Chalecystitis Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A H Hawkins M. D. or other
Address Cumb'd Md Date signed 4/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-E)

CERTIFICATE OF DEATH

03547

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:
223 Baltimore Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Baltimore Ave.
(If rural, give LOCATION)

2.(o) If veteran, name war

3.(a) FULL NAME Mrs Thelma Mae Mauk

3.(b) Social Security Number 214-07-2562

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Dale Mauk

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 24, 1908

8. AGE: Years	Months	Days	If less than one day
36	10	0	..... hrs. ..... min.

9. Birthplace: Star City W. Va.
(Town, county, and state)

10. Usual occupation: Textile Worker.

11. Industry or business: Celanese Corp.

FATHER 12. Name: Harry A. Higgins

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Minnie Ola Brewer

MOTHER 15. Birthplace: Unknown

16. Informant: Mrs Ethel Edenhart

Address: 63 Ruth St - Pittsburgh Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 26, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. April 26, 1945 (Date rec'd by registrar) Walter L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1945 19..... at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 44 to April 24 1945 and that I last saw h..... alive on April 22 1945

Immediate cause of death	DURATION
Hemorrhage	
Uterine Carcinoma	2 days
Due to: Carcinoma of Uterus	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Dan G. Murray M.D.
M. D. or other

Address: Cumberland Md. Date signed: April 25 45

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

03548

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 8 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA. County SOMERSET
City or town SAND PATCH, Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 1
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME MRS. ELIZABETH MAZER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife HOWARD MAZER
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 12, 1887

8. AGE: Years	Months	Days	If less than one day
57	9	28	..... hrs. ..... min.

8. Birthplace PA. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name JAMES HENRY SUDER
13. Birthplace PA.
MOTHER 14. Maiden name MATILDIA GEIGER
15. Birthplace PA.
16. Informant Memorial Hospital
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 13, 1945 (month) (day) (year)
Cemetery or crematory White Oak Union Cem.
Location Sand Patch, Pa., R.F.D. # 1
18. Funeral director H. F. Powers
Address 237 Main St., Meyersdale, Pa.
19. April 13, 1945 Walter R. Wantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 10, 1945, at 12:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 1945 to Apr 10 1945 and that I last saw h... ER alive on Apr 10 1945

Immediate cause of death	DURATION
Chronic Glomerulo -	2 yrs
Due to nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John A Topper MD M. D. or other
Address Hyndman Pa Date signed 4/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. KOON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03549

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 244 N. MECHANIC ST.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME MR. CHARLES McELFISH

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	25	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation MERCHANTILE
11. Industry or business LIVESTOCK FOOD

FATHER
12. Name JOHN McELFISH
13. Birthplace MARYLAND

MOTHER
14. Maiden name ISABEL DUNCAN
15. Birthplace PENNSYLVANIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 5 45 (month) (day) (year)
Cemetery or crematory Mt Pleasant Cem.
Location Allegany Co. Md.

18. Funeral director Louis Stein, Inc
Address Cumberland

19. April 5, 1945 (Date rec'd by registrar) Winter P. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 2, 1945 at 10;55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 29 1945, to April 2 1945
and that I last saw him alive on April 2 1945

	DURATION
Immediate cause of death Carcinoma of Thyroid. Cancer	2 yrs
Due to Exhaustion & Cough	1 Week
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Ford H Frantz M.D. M. D. or other
Address Cumberland Md Date signed 4/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03550

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, Institution, or street address where death occurred: 70 Race St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph H. Miller

3.(b) Social Security Number: 705-07-6625

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Athey

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct 10, 1876

8. AGE: Years: 68 Months: 6 Days: 13 If less than one day: ____ hrs. ____ min.

9. Birthplace: Berkley Springs W. Va. (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: B & O Ry.

FATHER 12. Name: Christian Miller

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Rachael Miller

15. Birthplace: W. Va.

16. Informant: Mrs Griffith Hensell

Address: 457 Penna. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 26 '45 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland

18. Funeral director: Louis Stein Sons

Address: Cumberland

19. April 26, 19 45 (Date rec'd by registrar) Walter P. Frantz M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 19 45, at 3 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 19 45 to April 23 19 45

and that I last saw him alive on April 23 19 45

Immediate cause of death: Chronic Valvular Heart disease — DURATION 3 Yrs.

Due to: Cystitis (Bacterial) —

Due to: Chronic Bronchitis — 5 Yrs.

Other conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. H. Devore M. D. or other

Address: 133 Va. Ave. Date signed: 4/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-L)

03551

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 8 days

Hospital, institution, or street address where death occurred: 573 Lowell Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For new-born infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 573 Lowell Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Victor St. Clair Monteith III

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17 1944

8. AGE: Years	Months	Days	If less than one day
1	0	26	..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Victor St. Clair Monteith II

FATHER 13. Birthplace Augustine, Ind.

MOTHER 14. Maiden name Bonnie E Mitzgus

MOTHER 15. Birthplace Ind.

16. Informant Mrs Victor St C Monteith

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. April 14, 1945 (Date rec'd by registrar) Walter R Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 13 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1944 to Feb 6 1945 and that I last saw him alive on Feb 6 1945

Immediate cause of death	DURATION
Uremia	3 days
Due to Hydronephrosis	
Due to Congenital Malformation of Kidneys.	1 yr 26 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE J. T. Corbett M. D. M. D. or other

Address 4 Greenett Cumberland Date signed 4/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

03552

1. PLACE OF DEATH

County Allegany Registration Dist. No. 4

Village [illegible] Cumberland No. Valley Road R 3 St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Betty Maxine Morgan

(a) Residence: No. Valley Road R 3 St., Ward. Cumberland Md

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Mar 23, 1944

7. AGE	Years	Months	Days	If LESS than
	1	0	15	1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Infant

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Cumberland (State or country) Md

FATHER

13. NAME Thomas H. Morgan

14. BIRTHPLACE (city or town) Cumberland (State or country) Md

MOTHER

15. MAIDEN NAME Alice Marie Beggett

16. BIRTHPLACE (city or town) Cumberland (State or country) Md

17. INFORMANT Thomas H. Morgan (Address) Rt. 3 Cumberland Md

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Rosehill Meth. Cemetery Date Apr 10, 1945

19. UNDERTAKER John J. Hosley (Address) Cumberland Md

20. FILED April 10, 1945 Hunter R Grantz M.S. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 8 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 7, 1945, to April 8, 1945

I last saw h... alive on April 7, 1945; death is said to have occurred on the date stated above, at 4:20 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	3 Days

Other **Contributory Causes** of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) F. Allan G. Thurm M. D.

(Address) Cumberland Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

03553

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No.: 202 Wood St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jeanetta Louise Llewellyn Mullan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James A. Mullan

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1866

8. AGE: Years: 79 | Months: 3 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Frostburg Alleg. Md. (Town, county and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER 12. Name: John R. Llewellyn

FATHER 13. Birthplace: Not known

MOTHER 14. Maiden name: Sarah Loar

MOTHER 15. Birthplace: Loarstown, Md.

16. Informant: Mrs. James A. Mullan

Address: 202 Wood St. Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 22 1945 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: Mrs. Day Boal Berry

Address: Westernport, Md.

19. 4-20 1945 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1945, to April 19 1945

and that I last saw her alive on April 19 1945

Immediate cause of death	DURATION
Chronic myocarditis	
Due to arterio-sclerosis	
Due to Senility	
Diher conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results:

PHYSICIAN: Please underline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in ths following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Dield M.D. M. D., or other

Address: Frostburg Md. Date signed 4/20/45

03554

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Eckhart (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If vetsran, name war

3.(a) FULL NAME: John David Myers
3.(b) Social Security Number: 220-10-4367

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Catherine Myers
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): July 5, 1871
8. AGE: Years: 73 Months: 9 Days: 11 If less than one day: hrs. min.
9. Birthplace: Eckhart Allegany Cty., Md. (Town, county, and state)
10. Usual occupation: janitor
11. Industry or business: Celanese plant
FATHER 12. Name: William Myers
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah J. Dudley
MOTHER 15. Birthplace: Maryland
18. Informant: Mrs. Catherine Myers
Address: Eckhart, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-19-1945 (month) (day) (year)
Cemetery or crematory: Eckhart Cemetery
Location: Eckhart, Md.
18. Funeral director: J. J. Dierst
Address: Frostburg Md.
19. 4-19 1945 Mrs. Nadie L. Rae Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 17 1945, at 11:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 13 1945 to Apr 17 1945 and that I last saw him alive on Apr 16 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 Days
Due to: Arteio-Sclerosis	Several years
Due to:	
Other conditions: Diabetes (Include pregnancy within 3 months of death)	Several years

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm C Lane Jr M.D. or other
Address: Frostburg Md Date signed: 4-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175-C

03555

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 426 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1.

3.(a) FULL NAME: Robert O. Nelson

3.(b) Social Security Number: 705-10-8536

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary McCallum Nelson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1897

8. AGE: Years	Months	Days	If less than one day
48	0	20	..... hrs. ..... min.

9. Birthplace: Conaine, W. Va. (Town, county, and state)
10. Usual occupation: Brakeman
11. Industry or business: Western Md. R.R. Co.

FATHER
12. Name: Absolom Nelson
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Ida F. Clayton
15. Birthplace: W. Va.

16. Informant: Mrs. Nola Beal
Address: 426 Greene St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 21, 1945 (month) (day) (year)
Cemetery or crematory: MillCreek Cem.
Location: Millcreek, W. Va.
19. Funeral director: Charles L. George
Address: Cumberland, Md.

19 April 20, 19 45 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18th., 19 45, at 5:43 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Fractured skull, at base.	about 17 hrs.
Due to (apparently assaulted by person or persons unknown; instrument used presumably a baseball bat)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no operation(dressings) Date of op. .....
Autopsy results: yes. As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 4/17/45
Accident, suicide, or homicide: under investigation. Date of injury
Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): street
Means of injury: apparently blows from baseball bat. Injured at work? No

23. SIGNATURE: Bruce H. Brown M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 4-19-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

03556

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (128)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Co. Infirmary
How long in hospital or institution? 2 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Bowmansdale Addition
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Cumberland, Md. Rt. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Amos Charlton Northcraft
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nan Robinson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1 1870

8. AGE: Years	Months	Days	If less than one day
75	1	22	hrs. min.

9. Birthplace: Near Hancock, Md
(Town, county, and state)
10. Usual occupation: Operated Pump House (Retired)
11. Industry or business: W. Md. Railroad
FATHER 12. Name: Silghman Northcraft
13. Birthplace: Cloverville, Pa.
MOTHER 14. Maiden name: Maria Lashley
15. Birthplace: Unknown
16. Informant: W. N. Northcraft
Address: Rt. 3, Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 26, 1945 (month) (day) (year)
Cemetery or crematory: Fairview Christian Cemetery
Location: Inglesmith Pa.
18. Funeral director: John J. Hafer
Address: Cumberland, Md.
19. April 26, 1945 (Date rec'd by registrar) Winter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1945, at 11:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4.10. 1945, to 4.23. 1945
and that I last saw him alive on 4.21. 1945

	DURATION
Immediate cause of death: Lobar Pneumonia	Due
Due to: Pulmonary Tuberculosis	10 Yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: None — Date of op.: None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other
Address: Cumberland, Md. Date signed: 4-25-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03557

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: 816 Greene St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 816 Greene St (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Lucy A. O'Leary

3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Dennis J O'Leary
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Nov. 1 1866

8. AGE: Years 78 Months 5 Days 6 If less than one day ....hrs. ....min.

9. Birthplace Miss (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Jno Murphy
13. Birthplace Md.
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Mrs Chas L Heskett
Address Cumberland Md
17. Burial (Burial, cremation, or removal Which?) Date thereof 4/10/45 (month) (day) (year)
Cemetery or crematory St P & P Cem
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19. April 10, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1945, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-31- 1945, to 4-7- 1945
and that I last saw her alive on 4-7 1945

Immediate cause of death Myocarditis — DURATION 1 yr
Due to Arteriosclerosis — 15 yr
Chronic Asthma — 40 yr
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. W. Elmerson M.D. or other
Address 136 Greene St. Cumberland Date signed 4/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

03558

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution? 7 7

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: Olympia Hotel (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Perros

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Not known

8. AGE: Years	Months	Days	If less than one day
70			..... hrs. ..... min.

9. Birthplace: Greece (Town, county, and state)

10. Usual occupation: Shoe Shine + Hat Cleaning

11. Industry or business

FATHER — 12. Name: George Perros

13. Birthplace: Greece

MOTHER — 14. Maiden name: Christina Tamis

15. Birthplace: Greece

16. Informant: John Sharis

Address: Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 5 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Maryland.

19. April 5 19 45 (Date rec'd by registrar) Walter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 — 5 — 1945 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30 1945, to 4-5-1945 and that I last saw him alive on 3-31-1945

Immediate cause of death	DURATION
Diabetes Mellitus	?
Due to Generalized	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 4-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

03559

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: McCoole Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: McCoole

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mildred Kitzmiller Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John F. Phillips

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1879

8. AGE: Years: 65 Months: 7 Days: 7 If less than one day: hrs. min.

9. Birthplace: Coss Mineral W Va (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Housewife

FATHER — 12. Name: Isaac Kitzmiller

FATHER — 13. Birthplace: Not known

MOTHER — 14. Maiden name: Nancy Blackburn

MOTHER — 15. Birthplace: Not known

18. Informant: John F. Phillips

Address: R.F.D. 3, Box 77 Keyser, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11 1945 (month) (day) (year)

Cemetery or crematory: Queen's Point

Location: Keyser, W. Va.

18. Funeral director: Walworth D. Boal

Address: Westernport, Md.

19. Apr. 11 1945 W. Grayson Baker M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 1945, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945 to April 8 1945 and that I last saw her alive on April 7 1945

	DURATION
Immediate cause of death: Cardio Vascular disease	Nov. 1944
Due to: Diabetes	5yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. G. Courrier M.D. (M. D. or other)

Address: Keyser W. Va. Date signed: 4-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

CERTIFICATE OF DEATH

Reg. Dist. No. 10

03560

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Mt Savage (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt Savage (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jane Agnes Pratt

3.(b) Social Security Number none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Richard Pratt
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 31, 1867
8. AGE: Years: 77 Months: 10 Days: 15 If less than one day: ..... hrs. ..... min.
9. Birthplace: Mt Savage Allegany Cty Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: home
FATHER 12. Name: Thomas Broderick
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Maria Welsh
MOTHER 15. Birthplace: Ireland
18. Informant: Anna Pratt
Address: Mt. Savage Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 21 1945 (month) (day) (year)
Cemetery or crematory: St. Patricks Cemetery
Location: Mt. Savage Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md.
19. April 20 1945 (Date rec'd by registrar) Vernie McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 1945 at 6 00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to April 1945
and that I last saw h... alive on April 15 1945
Immediate cause of death: Pernicious Anemia — DURATION: 3 yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jewell Trostle M.D. M. D. or other
Address: Frostburg Md Date signed: 4/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

03561

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Years

Hospital, Institution, or street address where death occurred:

Route 2, Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 2.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Arthur Riggleman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Riggleman

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): January 2 1883

8. AGE: Years	Months	Days	If less than one day
62	3	0	...hrs. ...min.

9. Birthplace: Franklin, Pennelton Co, West Va.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: William H. Riggleman
13. Birthplace: Franklin, W. Va.

MOTHER
14. Maiden name: Cassie Riggleman
15. Birthplace: Franklin, W. Va.

16. Informant: Mrs. Charles A. Riggleman
Address: Rt 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetrey

Location: Cumberland, Md.

18. Funeral director: William E. Kight

Address: Cumberland, Md.

19. April 4 1945 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1945, at 7-22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1944 to Apr 2 1945

and that I last saw h...alive on Dec. 10 1944

Immediate cause of death	DURATION
Carcinoma of Lung	7 yrs
Due to Metastasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Thos H Frazier M. D. or other

Address: Cumberland Md Date signed 4/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03562

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Stony Run Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Shirley Jean Riggleman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1945

8. AGE: Years 1 Months Days 20 If less than one day hrs. min.

9. Birthplace Westernport-Allegany-md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Kenneth B. Riggleman

13. Birthplace Westernport Md.

MOTHER 14. Maiden name Margaret A. Arnold

15. Birthplace Westernport Md

16. Informant Kenneth B. Riggleman

Address Westernport Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Apr 11 1945 (month) (day) (year)

Cemetery or crematory Bloom

Location Westernport md

18. Funeral director E. Llewellyn S. Good

Address Westernport Md

19. Apr. 11 1945 (Date rec'd by registrar) E. Lafayette Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9, 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945, to March 9 1945 and that I last saw h-- alive on March 8 1945

Immediate cause of death: Broncho Pneumonia

Due to: acute myocardial failure

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION
4 days
1 day

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Norman Reeves M.D. M. D. or other

Address Westernport, Md Date signed 4-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

CERTIFICATE OF DEATH

03563

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 849 Mt Royal Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Ritchey

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marie Ritchey

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 15 1887

8. AGE: Years	Months	Days	If less than one day
58	7	18	____ hrs. ____ min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: Restaurant

11. Industry or business: Corp.

FATHER
12. Name: James Ritchey
13. Birthplace: Pa.

MOTHER
14. Maiden name: Elizabeth Cross
15. Birthplace: Pa.

16. Informant: Mrs Grace Ritchey
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 6 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. April 6, 19 45 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/3 19 45 at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-26-45, 19__ to 4-3-45 19__ and that I last saw him alive on 4-3-45 19__

Immediate cause of death	DURATION
Acute Myocarditis;	duration 2 weeks
Due to Cause,	
Due to	
Other conditions Bronchial Pneumonia	3 days

(Include pregnancy within 3 months of death)

Major findings at operation: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. G. Zimmerman M.D.
M. D. or other

Address Cumberland Md Date signed 4-4-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

03564

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Mrs CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #2, BALTIMORE PIKE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MR. BERNARD ROMPF

3.(b) Social Security Number
217-16-6977

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 4 1887

8. AGE: Years	Months	Days	If less than one day
58	1	21	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation LABORER B.&O.R.R.

11. Industry or business Bolt & Forge

FATHER
12. Name JOHN ROMPF
13. Birthplace Unknown

MOTHER
14. Maiden name MARY KRAUS
15. Birthplace GERMANY

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/45 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Mt. Savage, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. April 27 1945 (Date rec'd by registrar) Walter A. Fantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 25, 1945 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 14, 1945 to APR. 25, 1945 and that I last saw h... alive on APR. 25, 1945

Immediate cause of death	DURATION
Chronic Hypertension,	6 mos
Duration: 5 years. Cwg	
Due to Coronary Thrombosis	2 wks
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Cleph Lamont M.D. or other

Address Cumberland Date signed 4/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

03565 4

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: West Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs.

Hospital, institution, or street address where death occurred: Narrows Park

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: West Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Narrows Park
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Charles Schoenadel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 25 1875

8. AGE: Years 69 | Months 8 | Days 3 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Trackman Retired 15 yrs

11. Industry or business: B. & O. R.R.

FATHER 12. Name: Charles W. Schoenadel

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Clara Oswald

MOTHER 15. Birthplace: Germany

16. Informant: Jos. Schoenadel

Address: Narrows Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 45 (month) (day) (year)

Cemetery or crematory: St Peter & Paul's Cem.

Location: W. Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. April 30, 1945 (Date rec'd by registrar) Victor L. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1945, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 27 1945 to Apr 28 1945 and that I last saw him alive on April 28 1945

Immediate cause of death	DURATION
Uraemia	2 wks
Due to Chronic Nephritis	years
Due to	
Other conditions Chronic Nephritis and Retinal Embolism	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: F. Allen G. Heinz M.D. M. D. or other

Address: Cumberland Md Date signed: April 30 1945

Dr. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03566

1454

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 Years

Hospital, Institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 3 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 227. Springdale St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mollie Lillie Scott

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Richard A. Scott

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 22 1869

8. AGE: Years	Months	Days	If less than one day
75	9	8	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: Thomas Donnley
13. Birthplace: Ireland

MOTHER
14. Maiden name: Harriett Zimmerly
15. Birthplace: Unknown

18. Informant: Richard B. Scott

Address: 227. Springdale St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 7 1945 (Date rec'd by registrar) Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945, at 5-30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-18 1945, to 4-30 1945

and that I last saw h.. alive on 4-28 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed 5-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

DR DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

03567

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1-7 HOURS
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Mineral
City or town: Ridgely Ford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: BABY BOY SIMMONS PREMATURE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APRIL 9, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Memorial Hospital Cumberland Allegany Co., Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: BURNESS D. SIMMONS
13. Birthplace: Roseville KY.

MOTHER
14. Maiden name: ELLEN IVA WHITTLE
15. Birthplace: Mammouth Cave KY.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/11/45 (month) (day) (year)
Cemetery or crematory: Ft Ashby Cemetery
Location: Ft. Ashby, W. Va.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. April 11 19 45 (Date rec'd by registrar) Nota R Dority M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 10 19 45 at 1:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 9, 1945 to Apr. 10, 1945 and that I last saw her alive on Apr. 9, 1945.

	DURATION
Immediate cause of death: Premature (2 days)	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clay E. Lupros M. D. or other
Address: Cumberland Date signed: Apr. 10, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

03568

CERTIFICATE OF DEATH

Reg. Diat. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 75 E Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 75 E. Main St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Shields

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles Shields

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 15 - 1868

8. AGE: Years 76 | Months 3 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Borden Shaft - alley - md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Martin Kenny

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Margret Logan

15. Birthplace: Ireland

16. Informant: Edw. Shields

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16-1945 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 4-15 (Date rec'd by registrar) 19 45 Mrs Maude H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 45 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1944 to 19 and that I last saw h[illegible] alive on April 1 1945

Immediate cause of death: Found Dead in Bed — DURATION

Due to: cerebral hemorrhage

Due to: Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W O M C Lane M.D. M. D. or other

Address: Frostburg Md. Date signed 4-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (174)

CERTIFICATE OF DEATH

03569

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memioral
How long in hospital or institution? Died on Admission

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main Ext.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry Skidmore

3. (b) Social Security Number: 236-03-3898

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Pauline Bosley Skidmore
6.(c) If alive, give age: 28 years
7. Birth date of deceased (mo., day, yr.): Feb. 2, 1905
8. AGE: Years 40 | Months 2 | Days 16 | If less than one day: hrs. min.
9. Birthplace: Moscow-Allegany-Md.
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal-Mine
FATHER 12. Name: John Skidmore
13. Birthplace: Frostburg, Md.
MOTHER 14. Maiden name: Margaret Arnold
15. Birthplace: Moorefield, W.Va
18. Informant: Pauline B. Skidmore
Address: Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 45 (month) (day) (year)
Cemetery or crematory: Bloomington
Location: Bloomington, Md.
18. Funeral director: E. Haworth S. Brad.
Address: Westernport, Md.
19. April 20 1945 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18th., 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19..... and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shock; Hemorrhage	
Due to Crushed right chest, frac.	2 hours
right tibia and fibula,	
Due to upper third.	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 4-18-45
Where did injury occur? Barton, (City or town) Allegany, (County) Mary; and. (State)
Injured at home, farm, industry, public place (where?) Coal mine
Means of injury Fall of rock Injured at work? yes

23. SIGNATURE: Pierce H. Bosley, M.D.
M. D. or other
Address: Cumberland, Maryland
Date signed: 4-18-45

County Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

03570

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18. Years

Hospital, institution, or street address where death occurred:
805. Bedford St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 805. Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George M. Sliger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Hardinger

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): September 11, 1864

8. AGE: Years	Months	Days	If less than one day
80	5	26	hrs. 7 min.

9. Birthplace: Bedford Co, Penna
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER 12. Name: Jacob Sliger

FATHER 13. Birthplace: Bedford Co, Penna

MOTHER 14. Maiden name: Clarissa Ash

MOTHER 15. Birthplace: Chaneysville, Pa.

16. Informant: Miss Linnie M. Sliger

Address: 805. Bedford St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/9/45 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Centerville, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 9 19 45 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 19 45 at 1-35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-6- 19 45 to 4-7- 19 45 and that I last saw him alive on 4-6- 19 45

Immediate cause of death	DURATION
Generalized Arteriosclerosis	?
Due to:	
Diabetes Mellitus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Md. Date signed 4-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

03571 4

Reg. Dist. No. .....

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 30 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sylvan Retreat

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Elizabeth A. Spies

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Anthony Spies

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
95			..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name: Unknown

13. Birthplace: "

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: Sylvan Retreat

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4/4/45 (month) (day) (year)

Cemetery or crematory: Sylvan Retreat Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. April 4 19 45 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 19 45 at 7-50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1. 1. 19 44 to 4. 2. 19 45 and that I last saw her alive on 3. 31. 19 45

	DURATION
Immediate cause of death: Generalized	
Due to: Arteriosclerosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed: 4-3-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

035729

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 30 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Stevens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17 - 1945

8. AGE: Years	Months	Days	If less than one day
		1	hrs. 30 min.

8. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: (None)

11. Industry or business

FATHER — 12. Name: John Stevens

13. Birthplace: Zihlman Md.

MOTHER — 14. Maiden name: Evaney O'Neil

15. Birthplace: Zihlman Md

18. Informant: John Stevens

Address: Zihlman Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-45 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg

18. Funeral director: J. F. Durst

Address: Frostburg, Md.

19. 4-18 19 45 (Date rec'd by registrar) Mrs. Vaney N. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17 19 45, at 5 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 19 45 to April 17 19 45

and that I last saw her alive on April 17 19 45

Immediate cause of death	DURATION
Prematurity	
Due to: b 2nd	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane Jr M.D. M. D. or other

Address: Frostburg Md. Date signed 4-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

03573 Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred: 12 N. Johnson Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 N. Johnson Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Andrew Gabriel Sullivan

3. (b) Social Security Number: 214-07-0761

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Loretta Govan
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): April 4, 1884
8. AGE: Years: 60 Months: 11 Days: 28 If less than one day: hrs. min.
9. Birthplace: Pekin Allegany - Maryland (Town, county, and state)
10. Usual occupation: Lift - Gateman
11. Industry or business: Celanese Springfield Co.
FATHER 12. Name: Sullivan
13. Birthplace: Ireland
MOTHER 14. Maiden name: Crow
15. Birthplace: Eckhart, Maryland
16. Informant: Mrs. Joseph Garlotz
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 1945 (month) (day) (year)
Cemetery or crematory: St. Patricks Cemetery
Location: Cumberland, Md.
18. Funeral director: W. M. Eichhorn
Address: Lonaconing, Md.
19. April 3 1945 (Date rec'd by registrar) Walter L. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1945, at 12:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to April 2 1945
and that I last saw h[illegible] alive on March 25 1945

Immediate cause of death	DURATION
Angina Pectoris	about 2 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. V. Denning M.D. M. D. or other
Address: 125 Bedford St. Date signed: 4/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-5)

CERTIFICATE OF DEATH

03574

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest towo)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town Near CUMBERLAND Rural
(If outside city or towo limits, write RURAL and give nearest town)
Street No. ROUTE #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. SILAS E. THOMAS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife MARY BURKETT
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) > 1867 <

8. AGE: Years 78 | Months > . | Days >, | If less than one day ... hrs. ... min.

9. Birthplace PENNA.
(Town, coooty, and state)

10. Usual occupation RETIRED - Railroader

11. Industry or business

FATHER
12. Name AUGUSTUS THOMAS
13. Birthplace PENNA.

MOTHER
14. Maiden name MORELLA NORTON
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26, 1945 (month) (day) (year)
Cemetery or crematory Hyndman Pa.
Location Hyndman, Pa.

18. Funeral director Harvey H. Engler
Address Hyndman

19. April 26, 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 24, 1945 at 11:07 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 18, 1945 to APR. 24, 1945 and that I last saw him alive on APR. 24, 1945

	DURATION
Immediate cause of death Carcinoma Stomach	6 mos.
Due to	
Due to	
Other conditions	

(Ioclude pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Iodustry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clark Durrett M. D. or other
Address Cumberland Date signed 4/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

035758

Reg. Diat. No. ____

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs

Hospital, Institution, or street address where death occurred: Beechwood

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No. Beechwood

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Joseph Todd

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Byrd

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 6, 1860

8. AGE:

Years	Months	Days	If less than one day
84	9	25	____ hrs. ____ min.

9. Birthplace: Edinburgh Scotland (Town, county, and state)

10. Usual occupation: Bailiff

11. Industry or business: Allegany Co. Court House

FATHER

12. Name: Frank Todd

13. Birthplace: Scotland

MOTHER

14. Maiden name: Rebecca Sharpe

15. Birthplace: Scotland

16. Informant: Dayton Butterbaugh

Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 7 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. April 7 1945 (Date rec'd by registrar) D. E. Boyington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3d 1945, at 10 15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__

and that I last saw h____ alive on ____ 19__

Immediate cause of death	DURATION
Coronary occlusion	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing Md Date signed: Apr. 7 '45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

03576

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs
Hospital, institution, or street address where death occurred: 1305 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1305 Bedford St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alvin Walter Twigg

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Trixie "Carder" Twigg
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): July 11, 1887

8. AGE: Years: 57 Months: 9 Days: 2 If less than one day ... hrs. ... min.

9. Birthplace: Town Creek, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Retired Rural Mail Carrier
11. Industry or business: U. S. Mail
FATHER
12. Name: Michael S. Twigg
13. Birthplace: Town Creek, Md.
MOTHER
14. Maiden name: Nora E. Crabtree
15. Birthplace: Town Creek, Md.
16. Informant: Mrs Alvin W. Twigg
Address: 1305 Bedford St.
17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Apr 19, 1945 (month) (day) (year)
Cemetery or crematory: Zion Memorial Park
Location: Cumberland Md.
18. Funeral director: John J. Hafer
Address: Cumberland Md.

19 April 17, 19 45 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

Louis Briggs –

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 19 45, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2nd 19 43, to April 13 19 45
and that I last saw him alive on April 1 19 45

	DURATION
Immediate cause of death: congestive heart failure	one year
Due to: chronic myocarditis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: [illegible]
Date signed: 4-16-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County ....

City or town .... (If outside city or town limits, write RURAL and give nearest town)

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State .... County ....

City or town .... (If outside city or town limits, write RURAL and give nearest town)

Street No. .... (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME ....

3. (b) Social Security Number

4. Sex .... 5. Color or race .... 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years .... Months .... Days .... If less than one day .... hrs. .... min.

9. Birthplace .... (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER: 12. Name .... 13. Birthplace

MOTHER: 14. Maiden name .... 15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal: Which?) .... Date thereof .... (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. .... 19 .... (Date rec'd by registrar) .... Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH .... 19 .... at .... m.

21. I HEREBY CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19 .... to .... 19 .... and that I last saw h............ alive on .... 19 ....

Immediate cause of death .... DURATION

Due to ....

Due to ....

Other conditions .... (Include pregnancy within 3 months of death)

Major findings of operations .... Date of ....

Autopsy results ....

PHYSICIANS: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) .... (County) .... (State)

Injured at home, farm, industry, public place (which?)

Manner of injury .... Injured at work?

23. SIGNATURE .... M. D. or other

Address .... Date signed

RECEIVED

APR 25 1945

3. V. S.

WARNING NEVER RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

VS 619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03577

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:
516. Shriver Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 516. Shriver Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Gertrude Loretta Twigg

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Henry Lee Twigg

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 24, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	9	...hrs. ...min.

9. Birthplace: Mt. Savage, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: William Morrison
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Sarah Close
15. Birthplace: Wellersburg, Pa.

16. Informant: Mrs. Stanley Daniels
Address: 636. Columbia Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3, 1945 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. May 2, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945 at 1 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1945 to April 30 1945

and that I last saw h... alive on 4/30/45 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: E Kester M. D. or other

Address: 121 Bedford St Date signed: 5/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. HAWKINS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-a

CERTIFICATE OF DEATH

03578

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1116 BEDFORD ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. GRACE WAGNER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife LAWSON N. WAGNER 6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) September 26, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	29	...hrs. ...min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation HWFE.
11. Industry or business
FATHER 12. Name WILLIAM J. BEASLEY
13. Birthplace VIRGINIA
MOTHER 14. Maiden name LILLIE BEALL
15. Birthplace MARYLAND
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/28/45 (month) (day) (year)
Cemetery or crematory Rose Hill Mausoleum
Location Cumberland, Md.
18. Funeral director William H. Kight
Address Cumberland, Md.

19 April 27 1945 Hunter D. Dent M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 25, 1945 2:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 23, 1945, to APR. 25, 1945 and that I last saw her alive on APR. 25, 1945

	DURATION
Immediate cause of death: Cardiac failure	
Due to: Coronary thrombosis	
Due to: Hypertension	
Other conditions: Arteriosclerosis	
(Include pregnancy within 3 months of death)	

Major findings of operations: Left breast Ca. Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. A. Hawkins M. D. or other
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-9)

CERTIFICATE OF DEATH

03570

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 RIDGEWAY TERRACE
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Virginia Lorraine Hagen

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 22, 1945

8. AGE: Years — Months — Days 6 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation none.

11. Industry or business

FATHER 12. Name JAMES WARREN

13. Birthplace Bristol Va.

MOTHER 14. Maiden name LORRAINE HAGER

15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 30 45 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland R.D.

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 30 1945 (Date rec'd by registrar) Walter L. Crouch M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 28 1945 at 5:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1945 to April 28 1945 and that I last saw h... alive on April 28 1945

Immediate cause of death	DURATION
Intestinal obstruction	6 days
Due to Imperforate anus.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Royce Hodges, M.D. M. D. or other

Address Cumberland Md Date signed 4-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

03580

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1201 Oldtown Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Dora Welsh

3.(b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Iskel Welsh
6.(c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.): March 17 1904

8. AGE: Years	Months	Days	If less than one day
41	0	15	......hrs. ......min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER
12. Name: Robert A. Bailey
13. Birthplace: Virginia
MOTHER
14. Maiden name: Gertrude Marion
15. Birthplace: Virginia
16. Informant: Memorial Hospital
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/6/45 (month) (day) (year)
Cemetery or crematory: Mt. Herman Cemetery
Location: Williams Road, Cumberland, Md.
18. Funeral director: William H. Kight
Address: Cumberland, Md.
19. April 6, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1945, at 6:50P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to April 2 1945
and that I last saw her alive on April 2 1945

	DURATION
Immediate cause of death: Influenza	4 days
Due to: following breast amputation for	
Due to: Adeno carcinoma	?
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: adeno carcinoma breast
Date of op. 3-1-45
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. M. Wilson M.D. (M.D. or other)
Address Cumberland Md. Date signed 4-3-45

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

03581

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 1/2 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. Church Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Bradford Lee Williams

3. (b) Social Security Number: 213-03-0345

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Bridget M. Williams

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 10 - 1901

8. AGE:

Years	Months	Days	If less than one day
43	10	30	...hrs. ...min.

9. Birthplace: West Union, W. Va.
(Town, county, and state)

10. Usual occupation: painter

11. Industry or business: cleaning corp.

FATHER
12. Name: Bradford Williams
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Lelia Dunmouth
15. Birthplace: W. Va.

16. Informant: Mrs Bradford Williams
Address: Mt Savage, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12-1945 (month) (day) (year)
Cemetery or ~~crematory~~: methodist
Location: Mt Savage, Md.

18. Funeral director: J. J. Dunlap
Address: Frostburg Md

19. 4-12 (Date rec'd by registrar) 19. [illegible] Mrs. Nancy M. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9th 19 45 at 5.05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26th 45 to April 9th 45
and that I last saw him alive on April 9th 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Vascular Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Mosley M.D.
M. D. or other

Address: Mt Savage Md. Date signed 4/10-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

03582

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred: 320 Bond St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 320 Bond St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Ada Wise

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: W. Edwin Wise

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): Dec 28 1870

8. AGE:

Years	Months	Days	If less than one day
74	4	2	...hrs. ...min.

9. Birthplace: Union Co. Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Daniel A. Miller

13. Birthplace: Pa.

MOTHER

14. Maiden name: Emma ———

15. Birthplace: Pa.

16. Informant: Mrs Aletta M. Cunningham

Address: 320 Bond St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3 '45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. May 3 19 45 (Date rec'd by registrar) Winter R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30th., 19 45, at 5:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Carcinoma of breast	One year.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Pierce H. Brush, M. D.
M. D. or other

Address: Cumberland, Maryland Date signed: 4-30-45

Deputy Medical Examiner for Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15